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ABSTRACT

This report describes the relationship between comprehensive prenatal care services and healthy babies, and examines the inclusion of social support services with medical care for women at-risk of problem pregnancies and unhealthy babies. The report notes that the United States trails many countries in indicators of maternal and child health. In 1989 Congress required states to expand Medicaid to pregnant women, and most states have established support services, such as home visiting. Although prenatal health services are vital, the most effective prenatal care programs include home visiting and other support services. Home visiting programs link high-risk pregnant women and infants to other important medical and social services. Examples of programs in Virginia, North Carolina, New York state, and Hawaii, which show promising results and cost savings are provided. Appendices give state-by-state information on Medicaid coverage for prenatal care and list key components of successful home visiting programs. (TM)

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When Health Care Is Not Enough: Support Services For Pregnant Women and Infants

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"For any further reductions in the United States' infant mortality rate, we must implement policy and program changes that recognize infant mortality is less a health problem than a social problem with health consequences." Resource Mothers Development Project

Many states continue to implement programs that encourage pregnant women to seek prenatal medical care. When state legislators also address the social needs of at-risk pregnant women, programs can become more effective in reducing the number of infant deaths and sickly newborns. Although prenatal health services are vital, the most effective prenatal care programs reach beyond the scope of medical services. Without outreach, risk assessment, home visits, nutritional education, transportation and appropriate referrals for treatment and counseling for high-risk pregnant women, financial coverage under Medicaid for medical care alone may not significantly improve the health of babies (1, p. 5).

Supplementing medical care with home visiting and other support services shows impressive results in promoting healthier babies and families:

- Teen mothers in Virginia's Resource Mothers Program had 46 percent fewer low-birthweight babies and 35 percent fewer infant deaths than teens in the same localities who were not in the program (2, p. 1).
- North Carolina saved $2.1 million in Medicaid expenses during the first two years of its Maternity Care Coordination program because fewer newborns required intensive care (3, p. 14).
- Hawaii's Healthy Start home visiting program saves child welfare and foster care costs by decreasing the number of families involved in child abuse and neglect investigations from an expected 20 percent of program participants to 1 percent (4, p. 45).

This report describes the relationship between comprehensive prenatal care services and healthy babies. It examines the inclusion of social support services with medical care for women at-risk of having problem pregnancies and unhealthy babies. In addition, it highlights the social support services provided through home visiting programs and examines state and local examples of such programs. The fiscal and programmatic issues, as well as recent federal action related to support services, are addressed. The appendices show state-by-state comparisons of Medicaid coverage for pregnant women and infants, provide information on each state's coverage of enhanced prenatal care services, and identify key components of home visiting programs.

Background

The United States trails many countries in indicators of maternal and child health. Our 1991 U. S. infant mortality rate was 8.9 deaths per 1,000 live births, ranking the United States 22nd in the world, behind nearly every developed country in the rate of babies who die during the first year of life (5, p. 6). With 7.1 percent of all infants born at low birthweight (less than 5.5 pounds) in the United States, 20 other countries have a better rate (5).

Some women have high risks for pregnancy complications that may lead to low birthweight or infant death. This "at-risk" distinction is typically based on factors such as maternal age, poverty, race, smoking, alcohol and other substance abuse, health complications, and inability to obtain health services. Social problems, such as domestic violence, and lack of family, community, or spousal support, also contribute to problem pregnancies (1, p. Ix). Experts agree that comprehensive

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prenatal care provided to pregnant women identified as "at risk" prove most effective in promoting healthy babies.

Why State Legislators Should Be Concerned

High infant mortality and low-birthweight rates strain both human and financial resources. Low birthweight is a leading cause of infant mortality and a primary factor related to lifelong disabilities such as blindness, deafness, cerebral palsy and mental retardation (1, p. 2). Hospital costs for a "normal" (full term, without complications) delivery average about $3,000, whereas costs for treating a sick baby in a neonatal intensive care unit range from $20,000 to $400,000. Annual hospital fees nationwide for neonatal services are estimated at $2 billion (1, p. x). The costs associated with sick newborns are profound and often disastrous for families, communities, employers, insurers, and health care programs administered and funded by local, state and federal governments (1, p. 1).

Many of these costs and problems could be avoided with prenatal care that includes both medical and social support services. Legislators are looking for policy options, information about effectiveness and costs of various strategies, and ways to best use their prenatal care money.

Federal Action

Congress has passed a number of measures requiring states to expand Medicaid eligibility for pregnant women. The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) requires states to provide Medicaid coverage for pregnant women and children up to age 6 with incomes up to 133 percent of the federal poverty level (1, p. 7). At least 33 states have adopted even higher income thresholds to include more women as they recognize the savings associated with providing prenatal care for low-income women (see Appendix A).

States may now also receive federal matching dollars for nonmedical support services for Medicaid-eligible pregnant women. Recognizing that many low-income pregnant women have needs that go beyond traditional medical care, most states have added a variety of ancillary services to their obstetrical Medicaid benefit packages. As of July 1993, 44 states had expanded the range of services available to Medicaid-eligible pregnant women (6). These Medicaid-enhanced prenatal care services include care coordination (case management), risk assessment, nutritional counseling, health education, psychosocial counseling, home visits, and transportation (see Appendix B).

The federal government also provides administrative matching funds for outreach activities that help find and enroll eligible women in Medicaid and help them obtain needed services. The administrative match reimburses states for up to 50 percent of administrative and outreach expenses. Some states have used this administrative match to help fund their nonmedical support programs that help Medicaid-eligible pregnant women obtain health services.

Each state has its own federal matching rate for Medicaid, ranging from a low of 50 percent to a high of almost 80 percent. State programs that use trained medical personnel such as doctors, nurses and social workers as home visitors for pregnant women may receive their designated Medicaid matching rate for enhanced prenatal care services. Some programs, however, effectively use case managers, trained lay workers, or volunteers as home visitors. In these cases, states do not receive their designated matching rate for medical services, but may receive the usually lower administrative matching rate of 50 percent for the outreach services provided by the home visiting program.

State Action

Most states have used new appropriations from general revenues to finance recent expansions in Medicaid coverage for pregnant women and children. About half of these states expanded eligibility for Medicaid and half both expanded eligibility *and* enhanced the package of services to Medicaid recipients. Some states reallocated funds from existing state-funded programs and others permanently reduced funds allocated to the health department for services to pregnant women, and transferred them to the Medicaid program to care for the same population. This way, federal matching funds were made available to increase the total pool of funds (7, p. 23). For example, in the first full year of its "Baby Love" Medicaid initiative, North Carolina legislators transferred $10 million in state funds allocated for various maternal and child health programs to the Medicaid program. With North Carolina's 65 percent federal matching rate, the state's $10 million leveraged approximately $18 million in new federal funds, bringing the total to about $28 million for the Medicaid expansions, which are described under "Home Visiting" (1, p. 13).

Support Services

By July 1993, 44 states had taken advantage of the opportunity to receive Medicaid reimbursement for one or more support services. In 1993 alone, seven additional states implemented programs of enhanced services or added new components to their existing programs (6) (see Appendix B for all states that provide these services).

- In March 1993, **Maine's** Medicaid progr .. began reimbursing for targeted case management for pregnant and postpartum women. Previously, state funds had been used for this service.

- As of July 1993, both **Missouri** and **New Hampshire** provide substance abuse treatment under their Medicaid-reimbursable prenatal care services.

- **New Mexico's** Health Department now provides a comprehensive package of support services to Medicaid-eligible women that includes care coordination, risk assessment, nutritional counseling, health education, psychosocial counseling, and home visiting.

- In June 1993, **North Dakota's** Medicaid program began reimbursing for care coordination, risk assessment, nutritional counseling, health education, and psychosocial counseling. This allows the state's public health units to receive reimbursement for services that they had paid for previously.

- In October 1993, **Vermont's** Healthy Babies Program started providing the complete package of support services reimbursable under Medicaid (see Appendix B). The program is administered by the Health Department and financed primarily through Medicaid.

- In January 1993, **Wisconsin** added a package of services for Medicaid-eligible pregnant women that includes care coordination, risk assessment, nutritional counseling and health education.

Home Visiting

Home visiting is one of the support services for which states may receive Medicaid reimbursement. This report focuses on home visiting because this service often provides the foundation for linking high-risk pregnant women and infants to other important medical and social services. A number of local and private programs have been providing home visiting services to pregnant women and new parents for years. States are beginning to follow these examples and maximize federal dollars by including home visiting in the package of support services available to pregnant women. See Appendix C for a list of key components of successful home visiting programs.

The federal government supports home visiting as an essential component of coordinated state systems of family services. Additional federal funds for the new family preservation and support legislation are currently available for states' home visiting efforts (Title IV-B of the Social Security Act, Subpart 2; OBRA-93 P.L. 103-66; 45 CFR Part 92). In an attempt to facilitate coordination of programs and develop a continuum of care at the state level, the federal government will provide additional funding to states where collaboration occurs among state agencies. The Request for Proposal (RFP) process will allow states to apply for up to $50,000 of additional funding if their Maternal and Child Health, Child Welfare, and Public Health Programs work collaboratively on the development of a health planning component of their family preservation and family support plan.

A 1990 U.S. General Accounting Office (GAO) report identifies home visiting as a "promising strategy that can help at-risk families become healthier and more self-sufficient . . . [and] which can reduce later serious and costly problems." The report identifies home visits as particularly beneficial for low-income, poorly educated or teenage parents (8).

Home visitors are nurses, social workers or trained lay workers who go into the homes of high-risk pregnant women and new mothers to teach them how to take better care of themselves and their new families, provide emotional support when needed, and link women to needed health and social services. Home visitors assist their clients during pregnancy, through the time of labor and delivery, and then work with the new mother and her family to promote positive parenting skills and preventive child health care (9, p. 5). By helping pregnant women gain access to prenatal medical care and other support services, home visitors help increase high-risk women's chances of having healthy babies (10, p. 3).

Internationally, home visitation programs have existed since the early 1900s. Today, home visiting is still the central feature of maternal and child health care programs in many industrialized countries.

Research and experience, both domestic and international, show that home visiting is successful in:

- reducing the incidence of low birthweight babies;
- increasing the use of preventive health care services such as prenatal care, well-child check-ups and immunizations;
- encouraging healthy behaviors, such as better nutrition and reductions in smoking or drug use during pregnancy;
- reducing the rate of accidents during infancy;
- reducing the incidence of child abuse and neglect;
- improving parenting skills;
- increasing children's IQ scores;
- decreasing the rate of school failure and welfare dependency; and
- generally promoting children's healthy growth and development (12, p. 1-2).

Several examples of home visiting programs follow.

Virginia

Virginia's Resource Mothers Program, one of the oldest and most successful home visiting programs, was recommended by the Virginia Task Force on Infant Mortality. Task force members concluded that providing support services targeted to high-risk pregnant teenagers would prove cost effective. As a result, resource mothers programs were established in several high-risk areas throughout Virginia (11, p. 22). Fifteen local programs receive funding from the state to administer the program. The state uses Maternal and Child Health (MCH) block grants and Medicaid administrative matching funds.

Targeted specifically to teenagers, the program served more than 1,000 teenage mothers between 1985 and 1991 (7, p. 21). Resource mothers are community lay workers who receive training in health, social services and counseling. They help teenagers get early prenatal care, reduce or eliminate unhealthy behaviors, and prepare for delivery and the needs of a newborn (11, p. 22). Caseloads range from seven to 15 teenagers per resource mother. The home visitors are supervised by a professional nurse and are paid a modest monthly stipend. In addition to the supervisor, an advisory board made up of civic, religious, business and health leaders oversees the program.

The results of the Virginia Resource Mothers Program are promising. In 1987, the incidence of low-birthweight births

was 46 percent less for teens in the programs than for teens in the same localities who did not receive services (5.9 percent compared with 10.9 percent). The reduction in the infant mortality rate was also significant, with a 35 percent difference between teen births in the Resource Mothers Program and all teen births in the state (10.2 deaths per 1,000 live births compared with 15.6 deaths per 1,000 live births) (2, p. 1).

North Carolina

Established in 1987, the North Carolina "Baby Love" initiative expanded the state's Medicaid program to improve access to health care and support services for low-income pregnant women and young children. In response to its high infant mortality rate, North Carolina expanded Medicaid eligibility for pregnant women and infants to 185 percent of the federal poverty level and enhanced the package of services available to include nonmedical support services (13, p. 1). To implement the Baby Love Program, legislators transferred about $10 million in existing state funds from several maternal and child programs to the Medicaid program, using the funds as a state match to obtain federal Medicaid money. This resulted in a total of about $28 million in perinatal care funds for the first full year of the program (1, p. 13).

The central component of the Baby Love program is a statewide system of perinatal case management, called Maternity Care Coordination, or MCC. Maternity care coordinators help eligible women receive services that address not only medical, but also nutritional, psychosocial and resource needs, such as adequate housing, transportation or treatment services. Coordinators also provide pregnant women with social and emotional support (14, p. 1,625).

The Baby Love program expanded in 1991 to include a home visiting component called the Maternal Outreach Project. This project employs lay home visitors to extend MCC into the homes of high-risk, isolated pregnant women (13, p. 6). The lay workers are extensively trained and are supervised by the maternity care coordinators. The addition of the home visiting component is funded under Medicaid (at the 50 percent administrative match level), using funds from a private foundation grant to supply the state's share (13, p. 6).

Evaluations of the MCC initiative show promising results. About one-third of Medicaid-enrolled pregnant women received care coordination services in 1988 and 1989. Even though the women who received the extra service were at slightly higher risk for problems as a group, they gave birth to significantly fewer low-birthweight babies and experienced lower rates of infant mortality. In addition, almost 73 percent of their newborns obtained well-child care by two months of age, compared with only 26 percent of the newborns whose mothers did not receive maternity care coordination services (3, p. 14).

In the first two years of the MCC program, newborn care costs were significantly lower for women who received care coordination ($1,694) than for those who did not receive MCC services ($1,971) (1, p. 14). Because fewer newborns required intensive care, North Carolina saved $2.1 million in Medicaid expenses during the first two years of its program (3, p. 14).

Elmira, New York

The Prenatal and Early Infancy Program (PEIP) began in 1978 as a home visiting program in Elmira, New York, with federal and private funds. When these funds phased out, the county picked up the successful program that provides support for pregnant women, new mothers and children. Elmira is a semi-rural area located in the Appalachian Mountains, with a population that is about 95 percent white. In 1980 this area was determined to be one of the most economically disadvantaged areas in the United States. Unemployment and child abuse and neglect figures were very high.

Dr. David Olds, a professor of pediatrics and a recognized expert on home visitation, developed a home visiting program to help families obtain health care, prepare for labor and delivery, learn about baby care, and make connections with support systems. As one of the only home visitation projects that used a random control group, PEIP's outcomes are considered statistically valid. In its research phase, the program served 400 pregnant women, many of whom were young, single parents living in poverty. Each woman was visited at home every two weeks by a trained nurse until the birth of the baby, once a week for the first six weeks after delivery, and then less frequently, but regularly, until her child was two years old.

Evaluations show that PEIP was able to help young mothers obtain needed services during pregnancy. Babies born to home-visited mothers weighed one pound *more* on average than the babies born to mothers in the control group. The home visitors helped pregnant women improve their diets and cut down on risky behaviors such as smoking. Program participants were also more likely to have a support person accompany them during labor.

PEIP visitors were successful in reducing child abuse, neglect and accidents among poor, unmarried teens. Only 4 percent of poor teen mothers who received regular nurse visits became involved with the child welfare system for suspected neglect or abuse, compared with 19 percent in the control group. In addition, PEIP showed a significant increase in the number of teens who returned to school and a significant decrease in the number of teens with repeat pregnancies. Among the unmarried program participants, the rate of unintended pregnancy during the four years after the project ended was half that of the control group.

More broadly, PEIP was able to facilitate a reduction in dependency on various systems of public aid among Elmira families. The average per family cost of the program in 1980 dollars was $3,133 for low-income families with young or unmarried mothers. Government savings were defined as decreased expenditures for Aid to Families with Dependent Children, Food Stamps, Medicaid and Child Protective Services, minus tax revenues due to maternal employment. According to this definition, government savings averaged $3,498 per low-income family with a young or unmarried mother by the time the children were four years old. Therefore, the cost of the program was recovered with a dividend of $180 for these families (11, p. 25-26; 16, p. 6-7; 15, p. 2 and 17).

Hawaii

Hawaii's Healthy Start Program serves at-risk families with children from birth through age five. Although the program does not begin in the prenatal stage, it exemplifies the home visitation model and has proved successful in improving the overall health and well-being of Hawaii's families. Nearly 50 percent of the state's newborns are screened in the hospital for social, developmental and health risk factors. Trained paraprofessionals provide a wide variety of support services to families who meet certain risk criteria and agree to participate in the program.

The Hawaii Legislature first funded the Healthy Start Program on a pilot basis in 1984 with $400,000. The enabling legislation promoted positive child development and child abuse prevention among high-risk families. (Hawaii Rev. Stat. sec. 321-36 et seq.). The appropriation grew to $7 million for the 1990-1991 biennium, and was recently increased by $1.5 million for the 1994-1995 biennium. Healthy Start receives Medicaid matching funds for targeted case management and is exploring the possibility of receiving Medicaid administrative matching funds for outreach (18).

The program targets families with newborns who meet certain risk criteria developed by the Kempe National Center for the Prevention and Treatment of Child Abuse. Program personnel invite families determined to be "at risk" to participate in the Healthy Start Home Visiting Program. Trained paraprofessionals visit families at home, initially on a weekly basis. In addition to serving as role models for parents, home visitors provide emotional support, 24-hour crisis intervention services, and developmental screenings. They also link families to services, such as medical care, food assistance, subsidized housing and parent support groups. Each paraprofessional works with between 15 and 25 families at a time.

Of the first 1,200 families served by the Healthy Start Program, fewer than 1 percent became involved with the child welfare system. According to program personnel, up to 20 percent of the families would be expected to become involved with child abuse or neglect investigations without early intervention services. Health department staff report that the reduced need for foster care saves the state substantial money (4, p. 44-45).

Conclusion

Programs that provide home visiting and other support services for high-risk pregnant women show promising results and cost savings. A variety of methods exist for funding these programs, including several options for states to capture more federal Medicaid dollars. Yet, support services are not silver bullets or cure-alls for helping mothers and children become and remain healthy (19, p. 113; 11, p. 3). Their effectiveness depends on a variety of factors including motivation by parents to obtain care, the availability and quality of other services, and the accessibility of medical prenatal care services. Social support services for high-risk pregnant women are considered by many to be an important part of comprehensive efforts to improve the overall health of mothers and babies.

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Appendix A
Medicaid Coverage Options for Pregnant Women and Infants
January 1994

State	Percent of Federal Poverty Guideline	Effective Date of Original Expansion
Alabama		Jul-88
Alaska		Jan-89
Arizona	140%	Jan-88
Arkansas		Apr-87
California	185%	Jul-89
Colorado		Jul-89
Connecticut	185%	Apr-88
Delaware	185%	Jan-88
D.C.	185%	Apr-87
Florida	185%	Oct-87
Georgia	185%	Jan-89
Hawaii	185%	Jan-89
Idaho		Jan-89
Illinois		Jul-88
Indiana	150%	Jul-88
Iowa	185%	Jan-89
Kansas	150%	Jul-88
Kentucky	185%	Oct-87
Lousiana		Jan-89
Maine	185%	Oct-88
Maryland	185%	Jul-87
Massachusetts	185%	Jul-87
Michigan	185%	Jan-88
Minnesota	275%	Jul-88
Mississippi	185%	Oct-87
Missouri	185%	Jan-88
Montana		Jul-89
Nebraska		Jul-88
Nevada		Jul-89
New Hampshire	170%	Jul-89
New Jersey	185%	Jul-87
New Mexico	185%	Jan-89
New York	185%	Jan-90
North Carolina	185%	Oct-87
North Dakota		Jul-89
Ohio		Jan-89
Oklahoma	150%	Jan-88
Oregon		Nov-87
Pennsylvania	185%	Apr-88
Rhode Island	185%	Apr-87
South Carolina	185%	Oct-87
South Dakota		Jul-88
Tennessee	185%	Jul-87
Texas	185%	Sep-88
Utah		Jan-89
Vermont	200% 225%	Oct-87
Virginia		Jul-88
Washington	185%	Jul-87
West Virginia	150%	Jul-87
Wisconsin	155%	Apr-88
Wyoming		Oct-88
Total Number of States Above 133 Percent Mandate: 34		

Notes: Unless indicated above, states cover pregnant women and infants up to 133 percent of the federal poverty guidelines, as mandated by OBRA-89. Minnesota and Vermont have taken advantage of flexibility afforded by section 1902(r)(2) of the Social Security Act to expand Medicaid coverage to this population above OBRA authority. In Vermont, the income limit is 200 percent for pregnant women and 225 percent for children under 16 years old.

Source: National Governors' Association, 1994.

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Appendix B
Medicaid Enhanced Prenatal Care Services
July 1993

State	Care Coordination/ Case Management	Risk Assessment	Nutritional Counseling	Health Education	Pyschosocial Counseling	Home Visiting	Transportation
Alabama	X	X		X	X	X	
Alaska	X	X	X			X	X
Arizona							
Arkansas	X	X	X	X	X	X	
California	X	X	X	X	X	X	
Colorado							
Connecticut	X	X	X	X	X	X	X
Delaware	X	X	X	X	X	X	
D.C.							
Florida							
Georgia	X	X		X	X	X	
Hawaii	X	X	X	X	X		
Idaho	X	X	X		X	X	
Illinois	X	X				X	
Indiana	X	X				X	
Iowa	X	X	X	X	X	X	
Kansas		X	X	X	X	X	
Kentucky			X	X		X	
Lousiana	X	X					
Maine	X	X	X	X	X		
Maryland	X	X	X	X	X	X	
Massachusetts	X	X	X	X	X	X	
Michigan	X	X	X	X	X	X	X
Minnesota	X	X	X	X	X	X	
Mississippi	X	X	X	X	X	X	X
Missouri	X	X					
Montana	X	X	X	X	X	X	X
Nebraska							
Nevada	X	X	X	X	X	X	X
New Hampshire	X	X	X	X	X	X	
New Jersey	X	X	X	X	X	X	
New Mexico	X	X	X	X	X	X	
New York	X	X	X	X	X	X	X
North Carolina	X	X	X	X	X	X	
North Dakota	X	X	X	X	X	X	
Ohio	X	X	X	X	X	X	X
Oklahoma	X	X	X	X	X		
Oregon	X	X	X	X		X	
Pennsylvania	X	X	X	X	X	X	X
Rhode Island							
South Carolina	X	X	X	X	X	X	
South Dakota	X	X		X			
Tennessee	X	X	X	X	X	X	
Texas	X	X					
Utah	X	X	X	X	X	X	
Vermont	X	X	X	X	X	X	X
Virginia	X	X	X	X		X	
Washington	X	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X	X
Wisconsin	X	X	X	X		X	
Wyoming							
TOTAL	42	43	36	37	33	37	12

Note: * As of July 1992
Source: National Governors' Association, 1993.

Appendix C

Key Components of Successful Home Visiting Programs

- Clearly defined goals, objectives and target populations (11, p. 12-16).
- An evaluation component from the outset.
- Home visitor services are offered on a voluntary (not mandated) basis, especially to high-risk women (15).
- Services are offered in the home (15).
- Services are intensive (15).
- Services are tailored to meet families specific needs (15).
- Services are comprehensive (e.g , substance abuse treatment, job training, if needed) and offer practical supports in the initial stages of child development (e.g., WIC and transportation to other services as needed) (15).
- The visitor focuses on friendship, trust, social support and respect (this appears to be the bottom line for clients and the common denominator of success regardless of the professional status of the home visitor) (15).
- Supervisors ensure that visitors are carefully selected, have a reasonable caseload, and are adequately trained and supervised (15; 17, p. 7).
- Home visitation services begin during pregnancy and follow the family at least through the first 24 months of a newborn's life (17, p. 7).
- Services reduce family stress by improving the social and physical environments in which families live (17, p. 7).
- Programs must consider cultural and other demographic variables (11, p. 12-16).

STATE LEGISLATIVE REPORTS

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